TANGAZA COLLEGE

CATHOLIC UNIVERSITY OF EASTERN AFRICA

SHARING HOPE WITH PEOPLE AND FAMILIES AFFECTED BY HIV/AIDS

A CHALLENGE TO THE ANGLICAN CHURCH

A LONG ESSAY SUBMITTED IN PARTIAL FULFILMENT FOR THE REQUIREMENTS FOR THE DEGREE OF BACHELOR OF ARTS IN RELIGIOUS STUDIES

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NAIROBI- KENYA.

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STUDENT'S DECLARATION

I, hereby declare that the materials and information used in this long essay is my original work, achieved through personal reading, scientific research and reflection. It has never been submitted to any other college or university for academic credit. All sources have been cited in full.

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REV. PROF. RAPHAEL WANJOHI

NAIROBI – KENYA 2002

DEDICATION

This work is dedicated to all HIV/AIDS caregivers but especially to "Nyumbani" Centre, a home for HIV/AIDS orphans in Karen, Nairobi-Kenya. We all share hope with affected families and pray that cure would be found soon to tackle the deadly virus.

NAIROBI – KENYA 2002

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When I reflect on the magnitude of this project, I am reminded of selfless lectures of Tangaza College, friends, family members and my co-workers who were very helpful in this research study.

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Last but not least is my secretary, Ms J. N. Mukonza, who assisted in typing this project. There are others whom I cannot mention here, but they all through wisdom and unconditional love pulled me through the rough roads.

I could not have made it without your support, may God bless you all.

ACRONYMS AND ABBREVIATIONS

HIV	(Human Immuno deficiency Virus)
AIDS	(Acquired Immune Deficiency Syndrome)
UNAIDS	(United Nations programme on HIV/AIDS)
PLWA	(People Living With AIDS)
NGO	(Non Governmental Organization)
MAP	(Medical Assistance Program)
VCT	(Voluntary Counseling and Testing)
WHO	(World Health Organization)
AHRTAG	(Appropriate Health Resources and Abbreviations Technologies Action Grow)
AMREF	(African Medical and Research Foundation)
DFID	(Development For International Development)
NCCK	(National Churches Council of Kenya)
KCS	(Kenya Catholic Secretariat)
CHAK	(Christian Health Association of Kenya)

"Nyumbuni" centre – is Agikuyu word for home. The name is given to a catholic Centre for HIV/AIDS orphaned children.

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CHAPTER ONE

1.0 GENERAL INTRODUCTION

1.1 BACKGROUND OF THE STUDY

1.1.1 Current state of HIV/AIDS pandemic in Kenya

The most life threatening disaster in the world today is Human Immune Deficiency virus (HIV) infection and the Acquired Immune Deficiency Syndrome (AIDS). It is a severe life-endangering epidemic caused by a virus spread through infected blood. The AIDS virus is spread through semen, vaginal secretion and blood transfusion. 75% of AIDS victims in Kenya get it through sexual intercourse. This new infectious disease is primarily a 'family disease'. This is because once one family member is infected by HIV/AIDS, other members of the family are naturally affected.

The following remark by the United Nations(UN) secretary general Koffi Annan serves to demonstrate this :

" This disease, HIV/AIDS, is all around us, within our community and our families and it will defeat our best efforts of development unless we defeat it first. [1]"

In 1996 alone, one million people died of AIDS, the adult death rose in 1997 to 2.3 million and the report further states that the people newly infected with HIV in 1997 were 5.8 million [2]. According to the new joint United Nations AIDS/World Health Organization (UNAIDS/WHO) report of June 1998, the HIV/AIDS epidemic continue to progress rapidly. Over 8,500 people are newly infected with HIV – the virus that cause

1. Daily Nation, Wednesday, July 11th 2001 (No. 12716) P.1-2
2. AMREF, Information on AIDS, Nairobi: AMREF Health Behaviour aand Education Department, P 7

AIDS. UNAIDS estimates that 30.6million adults and children are living with HIV/AIDS. 90% of these people live in Africa, Asia and Latin America. The UNAIDS report of the year 2000 states that, 36.1 million people were already infected globally [3]. Sub Saharan Africa had 3.8 million new cases by the year 2000.

The first case was diagnosed in Kenya in 1984. Since then, reported cases of HIV/AIDS have been rising. In 1993, about 780,000 cases of HIV/AIDS were reported. From January 1995 to June 1996, death toll attributed to AIDS was estimated at 60,000. Adult HIV prevalence in Kenya is expected to rise from 7.5% in 1995 to 10% in 2000, bringing to two million HIV+ people. In the same year the annual deaths of adults between 15 and 49 years due to AIDS is pegged at 200,000 and is likely to shoot to 300,000 by 2005. The cumulative number of AIDS deaths may rise to one million in 2000 and two million in 2005 [4]. Today in Kenya, the statistics point to between 600 to 700 deaths daily due to HIV/AIDS. Majority of them are the young economically productive people [5]. This brings hardship to families and increase expenditure on health care.

During the occasion marking 20 years of HIV/AIDS in Kenya, UNAIDS executive director, Peter Piot said that, AIDS is still in its early stages. By this he meant that more and more Kenyans are going to succumb to this epidemic in the years to come. This statement had dire consequences given the present destruction and deaths caused by the HIV/AIDS pandemic. There are reports that in some parts of Kenya, villages are being closed down, children 'bringing up' other children and elderly playing the role of parents.

3. United Nations Statistics found in website address, www. Unaids org/whats new/press/eng/pressarch 98/ gradrace. html.
4. NACOP/MOH/NCPD 1994 op. cit., P.19.
5. Republic of Kenya, Ministry of Health, sessional paper No. 4, 1997, on AIDS in Kenya.

Consequently, HIV/AIDS has been declared a national disaster in Kenya. Inspite of this, people have not changed their sexual behaviour.

Further more, it has been noted that care and support of People Living With AIDS and their families is minimal. Given that there are other challenges which distabilise the family in Kenya, e.g. poverty, politically instigated, ethnic clashes, corruption and urbanization, the family as a basic unit is seriously threatened. One is compelled to call every person of good will to share hope with the family in these hard times.

1.1.2 The agony experienced by People Living With AIDS (PLWAs)

During my first and second years in Tangaza College, I worked at St. John's Parish Mwimuto in Kiambu as an assistant Pastor where I used to accompany the Pastor in his pastoral visits to the people of Mwimuto. We once visited a lonely, deserted house. When the door was opened, we could not believe our eyes, out came a thin, frightened starving man who was barely dressed and seemed very sick. We prepared a meal for him which he ate as if it was the last meal. We also assisted him to take a shower and took him to hospital. It seemed that neighbours had no idea of what was happening to the man let alone the agony he was undergoing. He had no relatives nearby and so we were his only family. One week later, tied to a city national hospital bed, this man died of complications from HIV/AIDS. In the Parish of St. John's Mwimuto, HIV/AIDS is a reality. Many people together with their families suffer quietly. They fear the stigma and shame of being associated with HIV/AIDS.

Here, the stigma attached to HIV/AIDS is overwhelming. Most of the time, we found PLWA's and their families discriminated by the community. Stigmatization is claimed to have been institutionalized by both public and private sectors [6]. HIV/AIDS victims in St. John's are branded 'immoral'. People think that one gets HIV/AIDS through sexual misconduct. So they see it as punishment that is deserved by the victim. They think one got AIDS out of prostitution, adultery, fornication or through sex with multiple partners.

Some of the people in this Parish avoid victims of AIDS for fear of contracting the disease. They will not take Holy Communion if a person infected with AIDS also shares in the communion. HIV/AIDS is therefore a terrible, agonising blow because it tends to seclude one from what is normal. HIV/AIDS is a disease with emotions of psycho-social distress. The victim feels hopeless about the future. There is no cure, once you are infected. Therefore, there is an urgent need to share hope with PLWA's through care and support.

1.1.3 HIV/AIDS is a disease of burden

When HIV/AIDS attacks a family member, the employed person takes sick leave in order to be nursed. The family income is threatened. It is women who are the majority in the rural areas who are affected mostly by HIV/AIDS. When a woman dies, the family food security is at risk. This is because many families depend on her for food production. Women provide the labour that is required in generating food, in many families.

HIV/AIDS kills many parents living behind many helpless orphans. These children are now under the care of their aged grandparents. Their basic health and social

6. Shorter and Onyancha 'The church and AIDS in Africa' P. 74-112

needs are inadequately met. Many of them never go to school due to lack of school fees. Some are even left on their own and join the street families. In addition, the family income is reduced when money as to be spend on funeral expenses. The immediate family of the dead person experiences denial, anger and shame. They suffer severe psychological trauma. The person living with HIV/AIDS may even turn to self destructive behaviours like suicide. This is caused by fear of a prolonged painful illness. HIV/AIDS is therefore a burden to the affected families. As the burden of caring for the affected gets heavier, this may completely hinder the family growth economically. So we need to share hope with families which are affected by HIV/AIDS.

1.2 STATEMENT OF THE PROBLEM

Since HIV/AIDS was detected in Kenya, a lot has been done to tackle the pandemic. Most activities have centred on awareness campaigns. Over 90% of Kenyans are now aware of this deadly disease. The government, the church and NGOs are working hard to curb HIV/AIDS. The NCCK program on AIDS was started in 1989. Since 1986, the Kenya Catholic secretariat (KCS) has been involved in caring for people with AIDS. The Christian Health Association of Kenya (CHAK) has opened up many avenues of disseminating information and educational materials on AIDS. It has networks in 15 hospitals, 32 health centres and 183 dispensaries and clinics all over the country. However, much of what has been done has been on awareness and prevention of HIV/AIDS. There has been very little effort with regard to caring for those infected and affected by HIV/AIDS. Father Shorter and Onyancha are quick to point out that :

"Care is closely related to prevention and awareness. By caring for people who are affected by HIV/AIDS, the community is more enlightened of their problems [7]."

In view of this, the present study focuses on the consequence of HIV/AIDS and what follows after one is infected. Since there is much concentration of resources on critical issues of prevention e.g. "condoms". While the area of care and support of PLWAs has often been neglected.

The government of Kenya as part of HIV/AIDS control campaign is prepared to import 300 million condoms. This was announced by Dr. Kenneth Chebet, head of the HIV/AIDS control in the Ministry of health [8]. When I hear this as a Pastor, I ask myself, is this the only option? Is this the only way we can care for our people? The care accorded to PLWAs has been clouded by negative attitudes and responses. This attitude must be dispelled in order to share hope with the affected families. HIV/AIDS is not a disease of poverty, however, it spreads or flourishes in condition of poverty. Poverty increases the vulnerability to infection.

Once poor people are infected, they have few resources to cope with the burden. The state of poverty in Kenya calls us to share hope with the poor families that are affected by HIV/AIDS. However, people who give care to PLWA have to be careful. One can contract the virus through working with those infected [9]. This is one major problem which hinders people from giving care. It is recommended that care givers and other support groups should be regularly tested of HIV/AIDS. They must put extra care to disinfect equipment, garments and bedsheets. It is a universal precaution to avoid direct

7. Shorter and Onyancha 'The church and AIDS in Africa' P. 74-112
8. Daily Nation, Wednesday, July 11th, 2001 (No. 12716). P. 1-2
9. Theodore C. Eickhoff, m.d, Chief medical editor, infectious disease news.

skin exposure to blood and body fluids. Although there are many risks, we must try to share hope with people living with HIV/AIDS and their families.

Many people living with HIV/AIDS need care inspite of scarcity of hospital beds. There is an urgent need to review the current status of care needs for PLWA. We need to describe the most appropriate strategies for care of PLWA. This will help us identify effective intervention to improve quality of life of people with HIV/AIDS related disease. Only then shall we be able to share hope with the families affected.

1.3 OBJECTIVES OF THE STUDY

(i) To access the extent of care and support of families affected by HIV/AIDS.

(ii) To research and provoke the reader of the circumstance or state of families affected by HIV/AIDS (see, judge and act).

(iii) To identify the needs and benefits of caring for PLWA in order to show the reader the importance of care.

(iv) To challenge and encourage the reader to take an initiative in care and support of PLWA.

1.4 RESEARCH HYPOTHESIS

For us to realize the above mentioned objectives, the following hypotheses are highlighted:-

(1) There exists a serious prejudice that care and support for PEOPLE LIVING WITH

(2) AIDS (PLWA) is a bottomless pit.

(3) There is a poor idea or gross under estimate of the true extent of HIV/AIDS impact on the family.

(4) Care and support of people living with AIDS and family has been clouded by negative attitudes and responses.

(5) Many individuals even in church, hold the opinion that nothing can be done about HIV/AIDS.

All these beliefs undermine the 'care' agenda for HIV/AIDS infected people and their affected families.

1.5 SIGNIFICANCE OF THE STUDY

This study is vital according to the researcher view because:

(i) It is undertaken at the right time when the family is burdened and earnestly crying for help due HIV/AIDS pandemic.

(ii) This work exposes the effects of HIV/AIDS pandemic on the family.

(iii) It challenges the church to reconstruct and renew its Pastoral care approach in order to help the family effectively.

(iv) This study expresses clearly that if the HIV/AIDS pandemic is not defeated, the whole humanity is endangered.

(v) This research will benefit my church and other churches in sharing hope with affected families.

(vi) Most important to me as a Pastor, this project will motivate and enlighten me about the care and support of families affected by HIV/AIDS.

1.6 SCOPE OF THE STUDY

This research is limited to the needs of people and families affected by HIV/AIDS. Our focus will be more on care and support of the family.

1. We will base our research in a limited geographical area: viz St. John's Anglican Parish, Mwimuto in Kiambu.
2. We shall access the extent of care support given to people affected by HIV/AIDS.
3. This academic research attempts to find out more about care and support of families affected by HIV/AIDS. It will be conducted through, questionnaires and personal observations. All this is limited to St. John's Mwimuto Parish, in Kiambu District of Kenya.
4. Since basic family needs and care are the same. HIV/AIDS is a global problem and human needs are basically similar. Therefore this research is relevant and can be applied to other parts of the world.

CONCLUSION

We have presented the general plan of our research study. We are now ready to review from various authors who have dealt with the problem. Therefore, chapter two deal with literature review.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

The family is the primary vital cell of society. The society is made up of many families. Here people live and work together for the common good of the whole society. The purpose of the family is to provide the daily needs of its members e.g. food and shelter. There are two or more types of families. The first is the nuclear family. It is made up of husband and wife together with their children. The second is the extended family, sometimes called kinship groups. This is an extension of parent child relationship through several generations: it includes grandparents, grand children, cousins, uncles and aunts.

A composite family consists of two or more nuclear families that share a husband or a wife. The African family was mainly extended. The family in this set up was a reproductive unit. It provided a stable environment for the continuation of society. The family was expected to nurture the children who were born into the society. They were assigned a social status so as to know who they are in relation to others. They were provided with the required companionship and emotional support.

It was in the family where sexual relations were controlled between persons. This ensured a better and meaningful living.

2.2 THE FAMILY AND HIV/AIDS

The current family is under pressure. The family is being challenged and subjected to change. High mobility of society and moving from rural areas to the cities is one major problem. Urbanization and industrialization separate members of the family. This causes a strain on marriages. It is a major factor that causes divorce. Urbanization is said to affect family hospitality and sharing. The 'money' element or materialism that has been introduced in cities, undermines the social and religious aspect of the family life. The mass media also affects the family through the modern video culture, pornography, music, romantic stories and sexual exploitation affect the family members especially the youth.

There is the threat of generation gap. This causes a physical and psychological distance between parents and children. It seems there is no communication. The young people assume freedom and go for casual and trial unions. They also choose their partners freely. This leads them to moral disorientation and sexual promiscuity. Together with other usual threats in Africa and especially Kenya such as poverty, conflicts and wars, family displacements and break ups are bound to occur. The list is endless. The worst of all is the HIV/AIDS pandemic. This disease is primarily a family disease. The family as it is said is an "endangered species". HIV/AIDS is an expensive disease. When one member of the family is affected, the whole family is affected.

HIV/AIDS affect the health, social, psychological, economical and spiritual well being of the family. This disease comes in Kenya, a country that is already burdened

with health and economic issues. The family no doubt lives in very hard times. There is no cure for AIDS and no vaccine to prevent it. HIV/AIDS is by no means a disease to be ignored. It affects sexually active men and women of economic productive age. The church and all people of good will should share hope and accompany the family in these hard times.

2.3 SOCIO - ECONOMIC IMPACTS OF HIV/AIDS

HIV/AIDS pandemic has seriously affected the socio-economic service of the family. HIV/AIDS is a fatal disease that affects the most productive sector of population (15-49 yrs). An economy comprises of the production and exchange of goods and services and all the transactions that make it possible for the benefit of all. Here human resources are the most important. Therefore anything that is a threat to human life will naturally affect the economy. So HIV/AIDS puts the family and Kenyan economy on the edge.

As many parents die they leave orphans behind. These children are left under the care of their aged grandparents. The loss of parent in early childhood means the loss of a central figure of attachment in child's emotional life [10]. Some children witness their parents die of HIV/AIDS . They have psychological trauma by the manner in which their parents died. This may manifest itself in late adulthood. Change of home and guardian also crates chaos and disorganization in the lives of these children. Many children join the street family to earn their living. When HIV/AIDS attacks a family, they devote all

10. Osterweiss, et al. 1984

their resources to doctors and medicine. Financial and emotional resources are severely affected. HIV/AIDS increases poverty in families [11].

The family and the society loss civil servants, tax payers, potential investors, consumers and young people who are at the peak of their earning and reproductive capacity. Many companies cannot function now due to effects on HIV/AIDS. They increase death among management, professionals and skilled labourers slow the growth of the family and nation. Increased funeral costs and terminal benefits cause drawbacks to many companies. Death of PLWA in the rural areas affect the agricultural production: time spent in caring for the HIV/AIDS patient means less time is devoted to food production.

The cost of medical care is above the debt-burdened third world countries like Kenya. The HIV/AIDS virus has affected the population even with regard to life expectancy. 74% percent of Kenya 's labour force is engaged in small-scale farming. HIV/AIDS deprives the agricultural sector, the required labour force. These few examples give a brief overview of the state of families today. The family definitely needs to be supported.

2.4 CARE FOR PLWA AND THEIR FAMILIES

(A pastoral challenge to the church)

HIV/AIDS Pandemic is a challenge to the church. This is because AIDS affect the family which is the domestic church. The future evangelization of the church

11. Osterweiss, et al. 1984

depends largely on the family [12]. The church by character should care for people as Jesus used to do. Such a disaster, as HIV/AIDS calls for a moral and humanitarian responsibility from the church; to provide care and support to families. Ever since the pandemic manifested at self in Kenya, the church has done a lot. From awareness campaigns to prevention and education about HIV/AIDS. The church has undertaken initiative in training, health care, research and production of material on HIV/AIDS. The church has also taught people who train others on HIV/AIDS . The church surrounds the family with love. However, the church can do much more on care and support of PLWA.

Dr. Apolos Landay of Peru states that :-

"AIDS is a great challenge for the Church and I pray that God makes the church uncomfortable until we have taken over our task in this trial." Churches are community centred and service oriented, preaching and practicing Love, compassion and care for the disadvantaged and underprivileged in the society. The church took a revolutionary attitudes to social rejects, stigmatized of the society, for instance; women (Luke 7:36-50), lepers (Lev. 13), tax collectors and sinners. Biblically, human beings are created in the image of God. The church should work hard to maintain the image of God in humanity especially in the case of HIV/AIDS pandemic. The Rt. Rev. Wasonga, Bishop of Maseno diocese of the Anglican Church of Kenya (ACK) recently urged all people in position of authority to identify HIV/AIDS as a problem that need urgent attention.

Church organizations are capable of reaching communities not reached by the government. The church must struggle to convince people to change behaviors which

12 Familiaris Consortio - church document

promote spread of HIV/AIDS. However, the church needs to be aggressive in the area of care and support too. She can provide education on family life and sexuality. This can revive moral values. Some cultures are harmful and only provide avenues for more people to be infected with HIV/AIDS. The church caring for affected families can interpret cultural traditions in the light of the scriptures for a change. She can also implement better policies that help to keep family together. The Catholic Church has done very well in care of the orphans e.g. "Nyumbani Centre", However, there is still a need to do more. Other denominations can copy this move which demonstrates the concern. Above all the church can share hope with PLWA through pastoral care. The church has the word of truth, goodness, understanding and deep sympathy which can help lessen the stigma of HIV/AIDS.

The church's approach to pastoral care must be progressive, one that follows the affected family step by step. She can promote the family to a model which the creator intended. The church has to be sensitive to the needs of vulnerable members of the family e.g. the poor, sick, old, orphans and widows who are affected by HIV/AIDS. A church which cares for families will direct its interests, time, personnel and resources on PLWA and their families. The church must also act as security to the family. She should defend the family from hostile media and broadcasters, to avoid hurting the family. The bishops in the African synod noted with concern that 'marriage and family hold an important place in African life. They also noted that the family institution is currently under threat [13]. The church should care for the plight of women since they are the heart

13. Catholic Bishops, ' The African synod '

of the family. They suffer unimaginable magnitude and oppression. The church must re-evangelize the Christian families.

If care is not given to families, the precious partner of the church must promote unity and hope in this time of crises. The church is capable of providing some basic needs e.g. money for medical and funeral expenses. She can help the family deal with psychological trauma e.g. anger, resentment and bitterness. This care should be given in an atmosphere of honesty, freedom and acceptance. The church must be the agent of reconciliation for PLWA and God. This will renew the family strength to fulfil its intended mission and destiny.

2.5 BENEFITS OF CARE AND SUPPORT TO PLWA & THEIR FAMILIES

An HIV/AIDS infected person needs care just like any other person with another disease. There are many benefits of caring for the people living with AIDS:

(i) Care and support of people living with AIDS reduces suffering.

(ii) By caring for HIV/AIDS person and family, you are helping them to improve their quality of life.

(iii) Care and support of PEOPLE LIVING WITH HIV/AIDS prolongs the life of economically productive patient. It also reduces the care burden by decreasing time spent in hospital.

(iv) Care and support prolongs the HIV/AIDS patient 'disease free' time, so it can

highly be cost effective to provide care.

(v) People are willing to know their HIV/AIDS status when care and support are available and accessible.

(vi) Care and support for PLWA and their family can decrease the stigma.

(vii) It can strengthen HIV/AIDS prevention activities as the target audience is in contact with people living with the virus.

(viii) It may help prevent the spread of AIDS related illness that also infect other people.

(ix) Caring for PLWA can keep the person healthy and able to work for as long as possible. For example, support groups can come together in a safe place to share their difficulties and concerns.

This forum helps to relieve stress, anxiety and stigmatization. Discrimination can be minimised if not eradicated.

CONCLUSION

Our country is still not regarded a successful story in fighting against HIV/AIDS. Every effort needs to be geared towards prevention and care for the infected and affected people. We have come to the end of chapter two on literature review. It is now clear that this problem is reality. This is because many authors have studied and researched on the problem. The following chapter presents our research methodology.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter is important in our research because it presents systematic methods of data gathering. It is the basis of our study, with accurate assessment and effective evaluation of HIV/AIDS impact on family. All our conclusions and recommendations depend on this chapter. We conducted our research in St. John's Mwimuto Anglican Parish. " Mwimuto" is a Kiswahili word meaning 'beyond the river'. This village lies beyond Kitisuru river in Nairobi – Kiambu boundary. It is located 6 kilometres from Nairobi city. The village is often a meeting place for people from all walks of life. Today Mwimuto village is home to over 10,000 people. They come from different cultural backgrounds. This densely populated village has two main sections, namely 'Githumba' and Rurii. The first "Githumba", is an Agikuyu name for a suitable land for farming. The local people who are the Landlords live here. "Rurii" is a low, flat land where water lies. This is where the low class and poor people live. They earn their living by working in the nearby Nairobi estates, most of them work as cooks, watchmen, shamba boys, housemaids and casual workers. Mwimuto is a better place for them because rental houses are cheaper.

Near the Nairobi – Kiambu boundary is a beehive of evil activities. There is selling of illicit brew like "Chang'aa" and other hard drugs. These attract many people from other parts of Kiambu and Nairobi who come to enjoy life at Mwimuto.

This has resulted to widespread cases of immorality. Many people are now infected with HIV/AIDS. The Anglican Parish of St. John is in the heart of Mwimuto village. I choose to do research in this Parish because I did my Pastoral experience in this Parish for two years.

During our Pastoral visits in the Parish, I noted that HIV/AIDS was a real threat to the family. People suffered quietly due to fear of community stigmatisation. It was a shock to notice that even during funeral mass, families would not dare talk about HIV/AIDS pandemic.

The Pastor of St. John's Parish together with the catechist were doing everything to curb AIDS pandemic. They organized HIV/AIDS awareness campaign and workshops on how one can prevent himself from HIV/AIDS. All in all no adequate care and support was given to PLWA and the family. It seems like HIV/AIDS was a shameful disease to which no one wanted to be involved. The small health clinic nearby offers no meaningful care to people living with AIDS. It is from this background that I was compelled to do this research. To access the extent of HIV/AIDS impact on family. I believe that this research will provide effective evaluation which helps to improve and transform the current situation of the family in St. John's Parish. We hope to come up with meaningful strategies to care and support HIV/AIDS affected families. Through this research, the Anglican Church and Mwimuto community may be challenged to share hope with families affected by HIV/AIDS.

3.2 TARGETED SOURCE OF INFORMATION

In our research, we targeted people who can offer care to people living with

AIDS (PLWA). The two groups are: -

(i) The church leaders, who include Pastors and Catechists.

(ii) The family which is represented by different groups in the church e.g.

- Fathers group
- Mothers group
- Youth group

We also targeted the AIDS patients themselves and their families for information. Other source of data gathering is library, to get all written works on this area of study.

3.3 SOURCE OF DATA COLLECTION

Our major source of data gathering was through structured questionnaires and personal observation. Structured questionnaires were given to church leaders e.g. Pastors, Catechists together with groups representing the family. Personal observations were conducted by the researcher with the AIDS patients and members of the immediate family during Pastoral care visits in St. John's Parish. The other source of data gathering was in various libraries e.g. Tangaza college library, Nairobi University, Marist International centre library and other selected resources e.g. medical assistance program (MAP).

3.4 SAMPLING

During our research study, 200 structured questionnaires were distributed to the targeted group as explained before. Each group was given 50 questionnaires. To validate our finding, we went ahead and administered 50 questionnaires to the youth group of the neighbouring St. Peter's Ndunyu Anglican Parish. The research study was carried out among the youth and adults raging from 16 to 50 years.

Although Mwimuto Parish has a large population, we decided to select workable groups for meaningful and realistic study under limited time. When our questionnaires were finally returned and edited, twenty of the questionnaires were blank. Fifteen other questionnaires were incomplete and so were left with 165 questionnaires for our research study.

CONCLUSION

We have discussed the research methods used to collect data and tools used for data gathering. Now we are ready to analyse the information gathered in order to draw clear inferences. All this is presented in chapter four. In this chapter, we study, interpret and analyse the data collected from questionnaires and personal observation (see, judge, act)

CHAPTER FOUR

4.0 ANALYSIS AND INTERPRETATION OF THE DATA

4.1 INTRODUCTION:

This chapter now exhaustively present all the findings, interpretations and discussion of our research. It sheds light on the analysis of the data. The analysis and explanations are offered in a logically organized way to justify the hypothesis. These were framed on the basis of the objectives highlighted in chapter one, section 1.3. In addition, the researcher has provided tables, graphs and figures with a view of presenting a visual summary of the set of data coming directly from the research.

4.2 DATA ANALYSIS

HYPOTHESIS 1

❖ *There exist serious prejudice that care and support of PLWA's is a bottomless pit.*

Tables 4.1, 4.2, 4.3 and 4.4 show the responses of different pastoral agents over the statement.

TABLE 4.1

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
YOUTH	STRONGLY AGREE	35	58.3
	PARTIALLY AGREE	15	25
	DON'T AGREE	7	11.7
AGE 16 – 35	DON'T KNOW	3	5
	TOTAL	**60**	**100**

TABLE 4.2

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
MOTHERS GROUP	STRONGLY AGREE	23	57.5
	PARTIALLY AGREE	10	25.0
	DON'T AGREE	7	17.5
AGE 25 50	DON'T KNOW	0	0
	TOTAL	**40**	**100**

TABLE 4.3

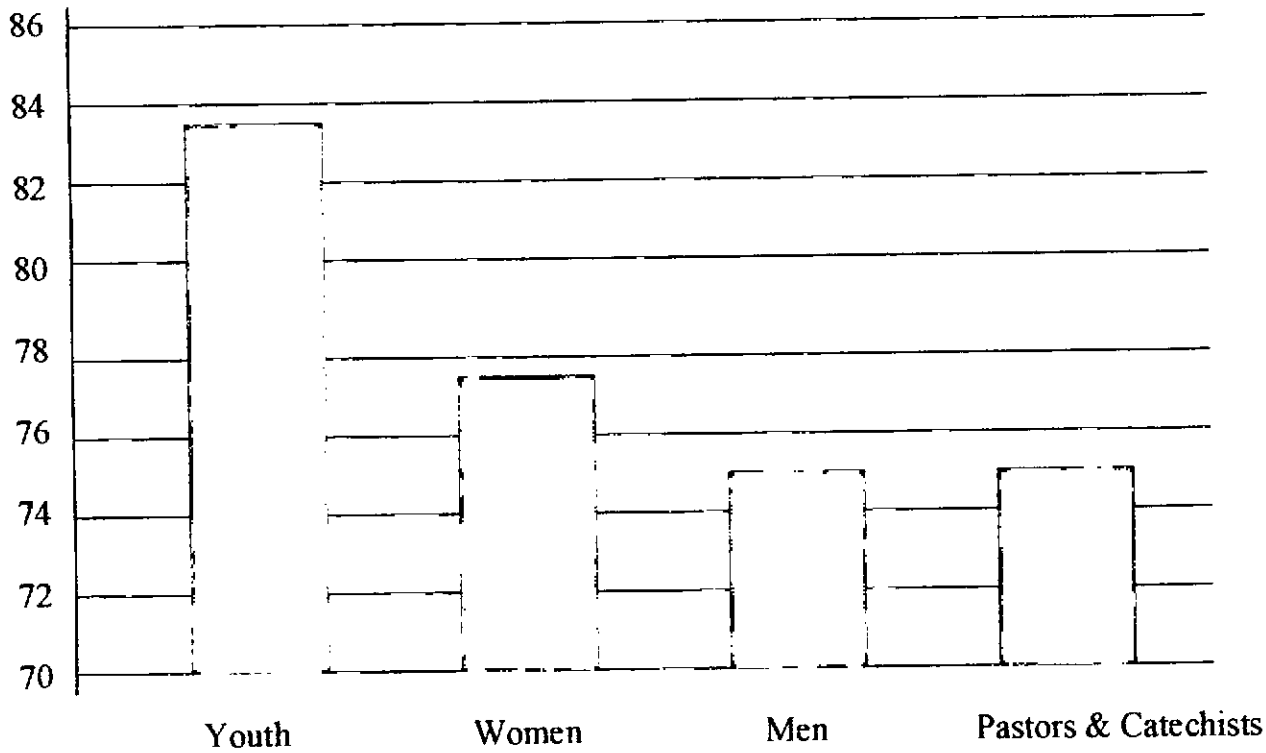
PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
FATHERS GROUP	STRONGLY AGREE	17	42.5
	PARTIALLY AGREE	13	32.5
	DON'T AGREE	6	15
AGE 25 50	DON'T KNOW	4	10
	TOTAL	**40**	**100**

TABLE 4.4

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
PASTORS &	STRONGLY AGREE	12	48
CATECHISTS	PARTIALLY AGREE	9	36
	DON'T AGREE	0	0
AGE 25 50	DON'T KNOW	4	16
	TOTAL	**25**	**100**

The bar graphs below represent the overall percentage scores on Hypothesis 1.

Bar Graph 1



Explanation of results

The tables 4.1, 4.2, 4.3 and 4.4 indicate various Pastoral agents responses to the statement, " That there exist serious prejudice on care and support of HIV/AIDS victims and that helping them is a bottomless pit ". Table 4.1 indicates the scores of youth who are seriously affected by HIV/AIDS. 35 (58.3%) out of 60 respondents strongly agree

that there was serious prejudice on care and support agenda. 15 youth (25%) partially agreed with the statement. In total 50 respondents (83.3%) agree with the statement. Among the 60 respondents, half were from the neighbbouring Parish of St. Peter's Ndungu. This was done to avoid generalizations.

Table 4.2 show the mothers or women group respondents who were 40 in number. 23 (57.5%) of them strongly agree with the statement. 10(25%) partially agree. In total, 33 women out of 40 agree with the statement that there is serious prejudice. The total percentage score is 77.5%. On the other hand table 4.3 indicate the scores of fathers or men group. There was 40 respondents. 17 men strongly agree with the statement. 13 partially agreed. In total, (75%) strongly support the statement. The other table which tested hypothesis 1 was 4.4 which represent pastors and catechists. There were 25 respondents. 12 strongly agreed with the statement while 9 partially agreed. The total score was 84%. These scores indicate that surely there is prejudice in the area of care and support of HIV/AIDS victims.

Finally, our bar graph 1 shows that the young people who are the most affected are the most sensitive about care and support agenda unlike the women, men and pastors and catechists.

The leaders of the church so still indicate that more need to be done on care and support. This indicates that prejudice hinders the care and support of HIV/AIDS victims. Thus the hypothesis is justified.

HYPOTHESIS 2

- *There is a poor idea or gross under estimate of the true extent of HIV/AIDS impact on family.*

TABLE 4.5

This table shows the score of youth on the statement of hypothesis 2.

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
YOUTH	STRONGLY AGREE	30	50%
	PARTIALLY AGREE	20	33.3
	DON'T AGREE	6	10
AGE 16-35	DON'T KNOW	4	6.7
	TOTAL	**60**	**100**

TABLE 4.6

This table shows the scores of the women on the standing hypothesis.

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
MOTHERS GROUP	STRONGLY AGREE	29	72.5
	PARTIALLY AGREE	5	12.5
	DON'T AGREE	4	10
AGE 25-50	DON'T KNOW	2	5
	TOTAL	**40**	**100**

TABLE 4.7

This table shows the scores of the men on the standing statement.

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
FATHERS GROUP	STRONGLY AGREE	16	40
	PARTIALLY AGREE	13	32.5
	DON'T AGREE	6	15
AGE 25-50	DON'T KNOW	5	12.5
	TOTAL	**40**	**100**

TABLE 4.8

This table shows the score of Pastors and catechists on the standing hypothesis to be tested.

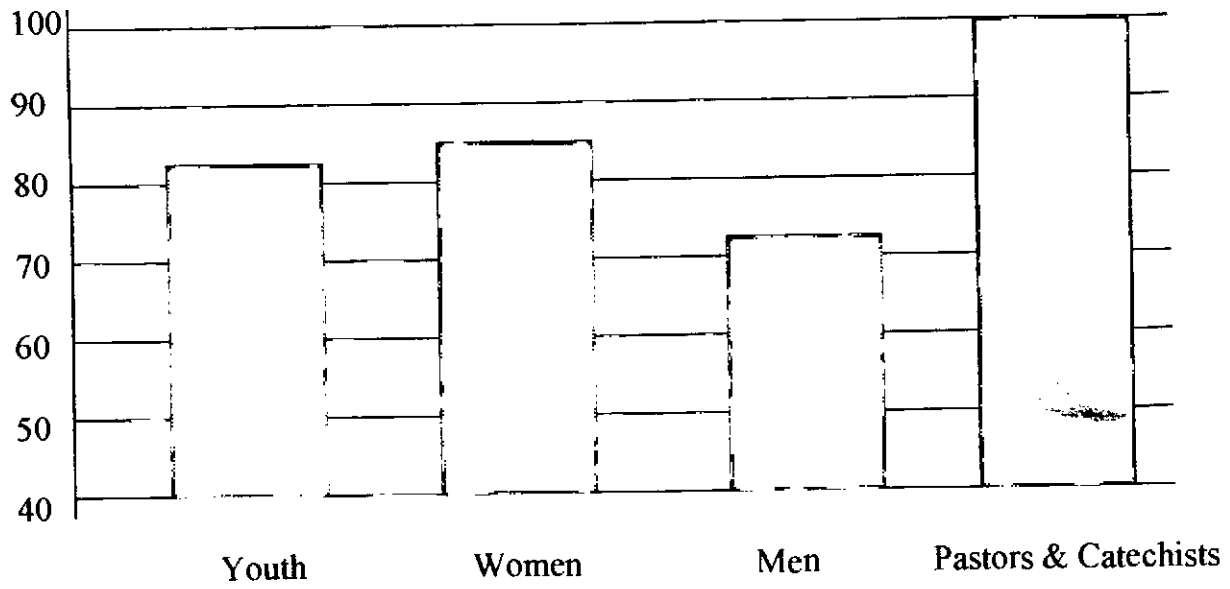
PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
PASTORS &	STRONGLY AGREE	15	60
CATECHISTS	PARTIALLY AGREE	10	40
	DON'T AGREE	0	0
AGE 25 -50	DON'T KNOW	0	0
	TOTAL	**25**	**100**

Table 4.5 shows clearly the scores of the youth on hypothesis 2. 60 respondents tested the statement. The table shows that 30(50%) youth strongly agree with the statement. 20(33.3%) respondents partially agree with the statement. In total, 50 respondents agreed that there is a poor idea or gross estimate of the true extent of HIV/AIDS impact on family. The youth agree with this statement and an outstanding

score of (83.3%) percent is observed. So the young people support hypothesis 2. Table 4.6 indicate scores of women on the same statement. 40 women responded. 29 of them strongly agree with the statement, while 5 of them partially agree. Therefore 85% of women who responded supported the statement. Table 4.7 shows men views on the statement. 40 respondents tested the statement. 16(40%) of them strongly agree with the statement, while 13(32.5%) partially agreed. A total of 29(72.5%) respondents agree with the statement. So our second hypothesis is strongly supported.

Finally, table 4.8 indicates pastors' and catechists' scores in view of the statement under test. 25 pastors and catechist respondend. 15 out of 25 respondents strongly agree with the statement while 10 of them partially agreed. The scores support the statement 100%. It is obvious that majority of people have a poor idea of the true extent of HIV/AIDS impact on family.

Bar Graph 2



Thus the second hypothesis stand justified.

HYPOTHESIS 3

- *Care and support of people living with HIV AIDS and family has been clouded by negative attitudes and responses.*

TABLE 4.9

Showing the response of the youth on the statement under test.

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
YOUTH	STRONGLY AGREE	40	66.7%
	PARTIALLY AGREE	15	25
	DON'T AGREE	5	8.3
AGE 16-35	DON'T KNOW	0	0
	TOTAL	**60**	**100**

TABLE 4.10

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
WOMEN GROUP	STRONGLY AGREE	35	87.5%
	PARTIALLY AGREE	2	5
	DON'T AGREE	2	5
AGE 25-50	DON'T KNOW	1	2.5
	TOTAL	**40**	**100**

TABLE 4.11

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
FATHERS/ MEN	STRONGLY AGREE	30	75%
GROUP	PARTIALLY AGREE	8	20
	DON'T AGREE	0	0
AGE 25-50	DON'T KNOW	2	5
	TOTAL	**40**	**100**

TABLE 4.12

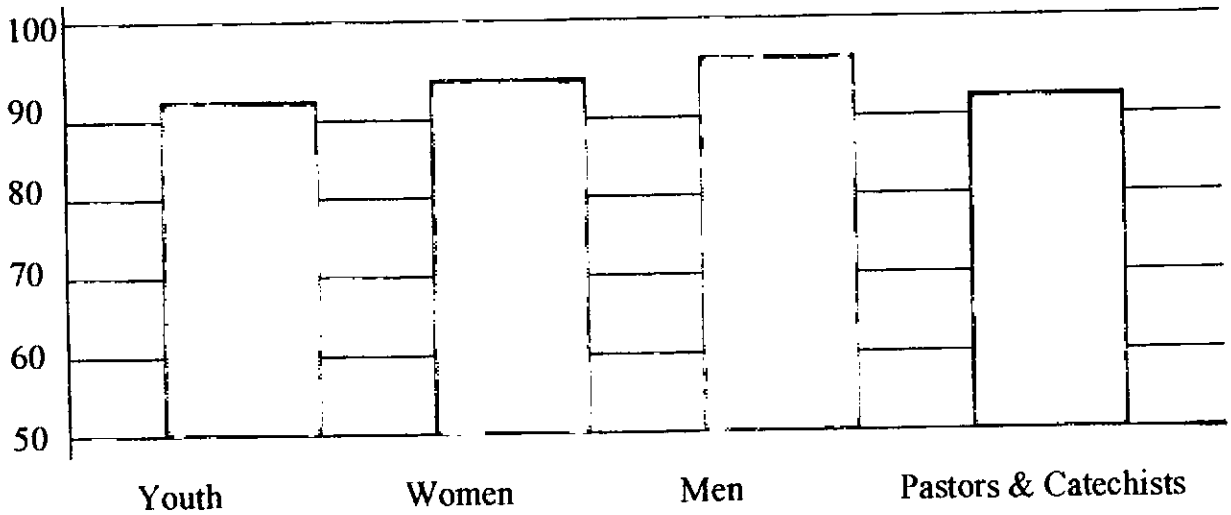
PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
PASTORS &	STRONGLY AGREE	20	80%
CATECHISTS	PARTIALLY AGREE	3	12
	DON'T AGREE	1	4
AGE 25-50	DON'T KNOW	1	4
	TOTAL	**25**	**100**

According to table 4.9, 40(66.7%) youth strongly agree with the statement, 15 of them partially agree which is a total of 55 out of 60 respondents. In view of this statement in question, the youth who agree scored 92%. These results justify hypothesis 3, that there are negative attitudes and responses on care and support of HIV/AIDS patients. The next table, 4.10 women scores on this statement. Out of 40 respondents, 35 (87.5%) percent strongly agree with the statement, while 2 partially agree. A total of 37 women respondents out of 40 agree that support and care of HIV/AIDS people is truly clouded by negative attitude and responses. A total score of 93% justifies our hypothesis 3.

Table 4.11 on the other hand indicates men's scores and views on the statement under testing. 30 men which is equivalent to 75% strongly agree with the statement, 8 of them partially agree. A total score of 95% support the statement. Therefore men justify hypothesis 3. Finally, table 4.12 shows the stand of church leaders (pastors and catechists) on the statement under testing. 20 church leaders out of 25 strongly agree with the statement i.e. 80%, while 3 partially agree. In total, 92% (percent) of the respondents agree with the statement.

Below is the bar graph which represent the total score.

Bar Graph 3



The bar graph shows overall scores on the standing hypothesis. It is clear that care and support of HIV/AIDS victims is clouded with negative attitude and responses. Hypothesis 3 is thus justified.

HYPOTHESIS 4

- *Many even in the church hold the opinion that with HIV/AIDS, nothing can be done.*

TABLE 4.13 show the opinion of youth on the statement under study.

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
YOUTH	STRONGLY AGREE	36	60%
	PARTIALLY AGREE	20	33.3
	DON'T AGREE	0	0
AGE 16-35	DON'T KNOW	4	6.7
	TOTAL	**60**	**100**

TABLE 4.14 shows the opinion of women on the statement under study.

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
WOMEN GROUP	STRONGLY AGREE	15	37.5%
	PARTIALLY AGREE	10	25
	DON'T AGREE	10	25
AGE 25-50	DON'T KNOW	5	12.5
	TOTAL	**40**	**100**

TABLE 4.15 shows the opinion of men on the statement under study

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
MEN GROUP	STRONGLY AGREE	26	65%
	PARTIALLY AGREE	14	35
	DON'T AGREE	0	-
AGE 25-50	DON'T KNOW	0	-
	TOTAL	**40**	**100**

TABLE 4.16 shows the opinion of church leaders on the statement under study.

PASTORAL AGENT	*OPTIONS*	*FREQUENCY*	*PERCENTAGE*
PASTORS &	STRONGLY AGREE	16	64%
CATECHISTS	PARTIALLY AGREE	4	16
	DON'T AGREE	5	20
AGE 25-50	DON'T KNOW	0	0
	TOTAL	**25**	**100**

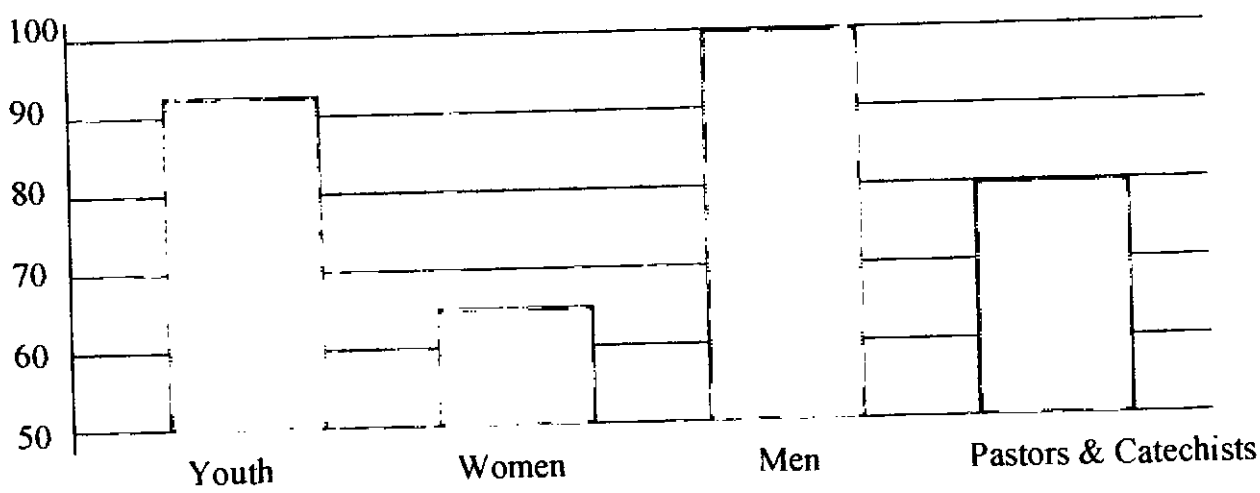
Table 4.13 above shows the scores of young people towards the statement that with HIV/AIDS pandemic, nothing can be done. 36(60%) youth out of 60 strongly support the statement. 20 others partially agree with the statement. Therefore, a total of 93.3% support the statement. Table 4.14 indicates women's stand on the statement of hypothesis 4. 15 women strongly support while 10 women partially agree with the statement. It seems women are not for the opinion that nothing can be done about HIV/AIDS pandemic. Therefore, 25(63%) women agree with the statement while the rest

25 are either not sure or do not know. Table 4.15 shows the scores of men on the statement under study. 26 men out of the 40 respondents strongly agree with the statement while, 14 partially agree. In total, men support the statement 100% as true. Therefore the hypothesis 4 is justified.

Table 4.16, shows the church leaders' view on the statement under scrutiny. 16(64%) church leaders (pastors and catechists) strongly support the statement. 4 of them partially agree with the statement. In total, 80 percent of the respondents support the statement. It is obvious then that many even in church, hold the opinion that nothing can be done about HIV/AIDS pandemic. Due to the lack of a cure for HIV/AIDS pandemic and the eminent death in the end, many think that with HIV/AIDS, that is the end of the road. So this opinion leaves a very little slim room for care and support of PLWA's. The fourth hypothesis is therefore justified.

Below is the total overall scores of pastoral agents on the hypothesis under study.

Bar Graph 4



CONCLUSION

So far, all the four hypotheses are tested, supported and justified. We have come to the end of chapter four. We have seen various responses and scores of the hypotheses under study. This strongly calls the church and people of good will to share hope with PLWA. The following chapter (five) presents the discussion, recommendations and finally the general conclusion of this study.

CHAPTER FIVE

5.0 RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

In this chapter, we now come to the close of our research study. We have presented the problems faced by people living with HIV/AIDS and their families. We now have a clear picture of the situation on the ground. In this final chapter, we shall now give our recommendations. In this chapter, we will also come up with a one-year Pastoral action plan for St. John's Mwimuto Parish. We shall finally present the general conclusion.

5.2.1 Provide counseling and basic information on HIV/AIDS

Counseling is one basic care element involved in HIV/AIDS care. This is a confidential discussion between a client and trained counselor and focuses on emotional and social issues related to possible or actual HIV infection.

- It can be done anywhere but needs a private and peaceful setting.
- It aims at providing the client with the information and support necessary to make decisions. It aims at reducing psychological stress. In addition, counselling has an important preventive aspect.
- Good counseling helps people make informed decisions. Both HIV/AIDS and their

those who care for them are able to live positively with HIV/AIDS.

- Counseling services must be provided in conjunction with medical and social support.

5.2.2 The youth and HIV/AIDS

The youth are exposed to HIV/AIDS due to biological, social-cultural and economic factors. The youth's vulnerability is increased by such factors as early exposure to sexual experiences through such influences as cultural, economic, media and erosion of traditional values.

These values were used as sanctions for regulating expression of sexuality.

- Provide direction in designing culturally and morally acceptable AIDS education programmes for the youth in and out of School.
- Advocate for protection of youth against anti-social behaviours such as premarital sex, drug abuse, teenage pregnancy and school drop out.
- Address the issue of poverty, unemployment and productivity in line with social dimension of development and the initiative for youth action. HIV/AIDS flourishes in poverty.
- The youth who are affected by HIV/AIDS need counseling, home-based care and employment creation.
- Provide support groups and networks of people with HIV/AIDS.

- Start more home-based care to support HIV/AIDS patients. This can be done through community –based approaches and community mobilisation. Home based care is less expensive for the already burdened family.
- Prolonged hospital admission can be a disaster to individuals e.g. risks of acquiring other diseases from other patients.
- Depression and loss of hope.
- It is difficult & expensive for family to visit. Home based care will help to decongest hospitals. It can help destigmatise HIV/AIDS.

5.2.3 Support and care for children orphaned by HIV/AIDS.

The church can start more homes like "Nyumbani centre" in Karen in order to care for these children. Families can accommodate these children in their homes.

- Improve access to essential drugs. Campaign for cheaper affordable drugs. The church can be in the fore-front in these campaigns.

5.2.4 Come up with self-help groups to provide support and strength to PLWA.

- They are a practical solution to social isolation. These self-help groups offer the opportunity for companionship, support and a chance to share experiences and discuss problems openly.

5.2.5 Support needs

- Help people with HIV/AIDS with daily household activities e.g. shopping, cooking and cleaning.
- Help them to access clean drinking water.
- Assist them with childcare.
- Help the affected family with subsistence farming .
- Assist with transport or mobility (market, health center e.t.c.)
- Help them with material needs e.g. soap, bed linen, clothes.
- Assist them with schooling and paying school fees.
- Help training & education in important facts about HIV/AIDS.
- Help them in encouraging the patient to live positively with HIV/AIDS.

5.2.6 Neighbours helping neighbours project

This may help in caring for HIV/AIDS patient e.g. delivering meals, cleaning apartments or taking sick people to the doctor/hospital.

- Sit together and accompany the sick or the dying neighbour.
- Advocate for persons with AIDS in hospital. Call their families and help them to understand.

This approach can be a combination of management, volunteers and support of neighbourhood service.

The main objective in this approach is:-

- To help (PLWA) stay at home and remain integrated in community life.
- Provide housing or shelter for those who have become homeless due to AIDS.
- Enhance the quality of life for PLWA and their families, prevent isolation and abandonment due to illness.
- Ensure that PLWA receive all available support, benefits, entitlements and services from the government, NGO's and other programs.
- Mobilize community human resources, including staff and resident volunteers to assist and support families affected by HIV/AIDS to meet other AIDS related community needs.
- Coordinate volunteer activities, including training and support program.
- Increase the community's understanding of HIV/AIDS and AIDS prevention measures.

5.2.7 Church approach in care & support

- The Church can provide education on sexuality and family life.
- Revive moral values and interprete cultural traditions which enhance the spread of HIV/AIDS in the light of the scripture.
- Aims at policies which keep the family together.
- Aims at caring for persons with HIV/AIDS especially the orphans.
- Develop support groups in the church which can offer various kinds of help.

- **N.B** The church needs to create a balance of confidentiality, trust and responsible communication.

5.2.8 Health education

It is important for good health. The church can facilitate and teach its people to achieve good health through their own actions and efforts.

The educator must be a good communicator who has genuine love for people.

5.2.9 Care for women with HIV/AIDS

- Encourage and support the self help groups and networks.
- The media should portray realistically, and not stigmatise, accessible & affordable health care.
- Women should be supported in their choices and rights. Women have heavier work burdens and lower earning rates than men and need to be supported.
- In conclusion, priorities for action should be based on knowledge and information not prejudice.
- In care and support, there must be fair spread of resources allocated for HIV/AIDS people.
- We must reinforce the fact that HIV/AIDS is now a broad development issue thus needs a combined effort of all.

- We must seek out and support the local initiative which combines care and prevention of HIV/AIDS.
- Whatever little is done in care & support of HIV/AIDS should be well coordinated.

Finally, the church (Anglican Church of Kenya) must be aggressive in the care and support of PLWA and their families more than ever before.

The need for hope is universal. Hope is how we choose to cope with life and death. Both the caregiver and PLWA need grace. Through the discovery of shared hope, we will find a cure, beating the odds stay focused on life, denying the reality of death and desire for quick painless death and minimum suffering.

5.2.10 Pastoral care to AIDS patient

- Visiting
- Prayer
- Spiritual encouragement
- Counseling
- Financial support
- Evangelism
- A Relation of openness & trust

Patient of HIV/AIDS and the affected families should observe the following:-

Patient of HIV/AIDS and the affected families should observe the following:-

- A well balanced diet
- Avoid smoking
- Keep fit (exercises)
- Avoid unnecessary drugs
- Sufficient rest
- Positive mental attitude
- Early symptoms treatment
- General hygiene

5.3 One year pastoral action plan for St. John's Mwimuto Parish

5.3.0 Introduction

We have come up with recommendations on care and support of PLWA and their families. We hope that the church shall utilize these proposals in order to help the affected people. We will now draw a one-year Pastoral action plan. This is meant to put into reality and action, what we have recommended. This action will be carried out by various groups and individuals in the church e.g. women groups, men groups, youth, church leaders, families and other groups in the neighbourhood.

All the activities proposed here will be evaluated after every 4 months.

Below are the details of the action plan.

5.3.1 What pastoral plan

Commitment in care and support of HIV/AIDS people and their families.

5.3.2 Where to implement the plan

This Pastoral plan will be implemented at the Parish level. This will be done within every group which represents the family in the church, for example, the fathers, mothers and youth. Other groups in form of fellowships will be involved as stated below:

- Singles fellowship
- Young couples fellowship
- Windows fellowship

5.3.3 Who implement the plan and how

(i) Men will start a HIV/AIDS support group. This will help to bring PLWA together. They will be offering care and support e.g. spiritual nourishment and counseling e.t.c.

Men's associations will also organize visits and assistance to the HIV/AIDS orphans. The long term plan will be to start a home for the HIV/AIDS orphans.

(ii) Women or the mothers union will be actively involved, first with home based care group. There will also be trained counselors among them to care and support PLWA and their families.

Women will be involved in prevention and care campaigns. This will be achieved

through conferences, workshops and rallies.

(iii) The youth in their groups will be used to educate their peers about HIV/AIDS. This will be done through workshops and seminars.

The youth will be assisted to start a change of behaviour campaign group. They can communicate this message through music and drama. Some of the youth will also be trained as counselors to help PLWA.

They will also start a support group for young people who suffer from HIV/AIDS. The youth will also help in various ways in home based care.

(iv) The other fellowships within the Parish will help to care and support PLWA and their families in various ways such as:-

- The young couples' fellowship will be teaching young families matters of care and support of HIV/AIDS patient.
- The singles' fellowship will start a feeding programme for poor people affected by HIV/AIDS.
- The widows will start a prayer and evangelism team for families affected by HIV/AIDS. They will also start a grief support group to comfort, care and help those families who their beloved die of HIV/AIDS.

(v) Pastors, elders and catechists will act as facilitators. They will help every group to organize itself.

They will help groups to collaborate in this common goal, which is to care and support families affected by HIV/AIDS. The Pastors and other leaders of the church will sit and

arrange to assist these groups financially to be able to achieve their goals.

5.3.4 Slogans for the Pastoral plan

- Say 'yes' to PLWA
- The caring community
- There is hope
- United we stand, divided we fall
- The light shines in darkness
- We are for life and hope
- Give them assistance and support
- Silence breakers
- Positive attitude towards HIV/AIDS

GENERAL CONCLUSION

When I was thinking about the conclusion of this research study, I remembered watching a very touching movie on T.V. It was about a warm loving family that had gathered to celebrate Christmas together. They came to know that one of the sons in the family was HIV positive. The father warned everybody not to kiss or touch his son because he was sick. A few weeks later, this young man was struggling alone in hospital. When the hospital attendants called the father to visit the son, he was furious. He said with HIV/AIDS, nothing could be done. He was interrupted and told No!, there is no cure but

you can show love and care to the infected person.

During this research, we note that different approaches and initiatives have been implemented within the field of HIV/AIDS care and support. However, little has so far been achieved for, a majority of the people do not know their HIV/AIDS status. And those who do not know their status receive little or no specific HIV/AIDS care and support. They usually only access a very limited range of appropriate care. HIV/AIDS pandemic like famine or war increases poverty to families. This research study is verified and the main objectives achieved successfully. A lot of wonderful work has been done in this field of study. This is well reflected in chapter two which is literature review. The work done by various authors gave us a firm foundation and encouragement to carry out more research. We did carry out a careful and thorough research on the problem. At least we are now confident to say those persons infected and affected by HIV/AIDS need care and support. That way, we can share hope with them. There is an urgent call and it is a challenge to the Anglican Church of Kenya and all people of goodwill to care for them.

Chapter four of our work shows clearly the research findings. We tested and proved all the hypotheses. We finalize with a discussion on data analysis, then go ahead and attempt to propose some recommendations on care and support of PLWA. These recommendations are not an end in themselves. We do not give the final solutions to the problems highlighted. What we suggest is only a tip of an iceberg. The battle with HIV/AIDS is far from being won. This research is only an eye opener and a challenge to those who are concerned and care. I believe many, through this work will be touched to share hope with the affected families.

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APPENDIX ONE

Questionnaire A

Below is the format of the questionnaire which was distributed to the pastoral agents in St. John's Mwimuto Parish

I am carrying out research to know more about People Living With AIDS and their families. Your cooperation in this project would be of great help in this research, which is a partial requirement of a B.A in religious studies.

Please indicate the following.

1. NAME _____ (optional)
2. AGE _____ SEX _____

1. How are families affected by HIV/AIDS pandemic in your parish.
2. List your major problems which they face.
3. How do your parish help PLWA and the affected families .
4. What do you suggest can be in order to share hope with affected families

APPENDIX TWO

Questionnaire B

The following is the format of the questionnaire which was distributed to different groups in the parish.

I am undertaking an intensive research to know more about care and support of People Living With AIDS and the affected families. Your co-operation in this research would be of great help, which is a partial requirement of a B.A in religious studies.

Please give the following details

1. NAME _____ (optional)
2. AGE _____
3. SEX _____

(*Please tick where appropriate*)

Strongly agree	Partially agree	Don't agree	Don't know

1. There exist a serious prejudice regarding care and support for people living with AIDS
2. many have a poor idea or underestimate the true extent of HIV/AIDS on families
3. People have negative attitude and responses towards care and support of people living with AIDS .
4. Many people think that nothing can be done about HIV/AIDS pandemic that it is a bottomless pit .
5. These beliefs undermine the effort to care and support of people living with AIDS and the affected families